Electronically delivered
August 28, 2020

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

RE: CCN: 245485
Cycle Start Date: August 11, 2020

Dear Administrator:

On August 11, 2020, a survey was completed at your facility by the Minnesota Departments of Health , to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 11, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 11, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
August 28, 2020

Administrator
Johnson Memorial Hosp & Home
1290 Locust Street
Dawson, MN 56232

Re: State Nursing Home Licensing Orders
Event ID: S9DV11

Dear Administrator:

The above facility was surveyed on August 3, 2020 through August 11, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00326	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	**1290 LOCUST STREET DAWSON, MN 56232**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/4/20 through 8/11/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED: H5485012C, H5485016C,	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/07/20

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2 000	Continued From page 1 and H5485021C, however NO orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5485013C, H5485014C, H5485015C, H5485017C, H5485018C, H5485019C, and H5485020C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	C 08/11/2020

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JOHNSON MEMORIAL HOSP & HOME	**1290 LOCUST STREET DAWSON, MN 56232**

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F 000	INITIAL COMMENTS On 8/4/20 through 8/11/20 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5485012C and H5485021C and had a deficiency cited at F744. Additionally, H5485016C was found to be SUBSTANTIATED, however no deficiencies were cited. The following complaints were found to be UNSUBSTANTIATED: H5485013C, H5485014C, H5485015C, H5485017C, H5485018C, H5485019C, and H5485020C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the	F 744		10/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/07/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 744	Continued From page 1 appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure staff who cared for residents with dementia were appropriately trained prior to working with 2 of 2 residents (R2 and R10). Findings include: Review of state agency (SA) report dated 10/20/19 at 8:00 p.m., R2 reported she did not want nursing assistant (NA)-C to be in her room. NA-C had used a threatening tone towards her and tells her what to do. She was afraid of NA-C as she did not know what she would say or make her do and she made her feel stupid. NA-C's attitude and tone of voice was what had upset her. BIMS indicated severe cognitive impairment. Staff member was no longer working with the resident and was required to complete dementia training and provide a summary to the DON. The DON would perform audits with residents regarding the staff member. Review of the 10/24/19 Employee Counseling and Disciplinary Action identified NA-C received a written warning. Description of the problem identified R2 reported she did not want NA-C in her room and had described her as being bossy and telling her what to do. DON had reviewed the behavior report 9/21/19 to 10/21/19 and noted 4 incidents of behaviors, 3 were documented by NA-C. Further identified that 5 other residents reviewed had increased behavior documentation when NA-C provided cares. The DON identified a suspicious pattern of residents reacting	F 744	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: DON sent NA-C home following report of the inappropriate treatment toward R10. Following facility investigation, DON and Administrator met with NA-C on 8/6/20 and NA-C was given a final written warning with the following performance improvement requirements: NA-C will participate and complete the Dementia Live training program provided by a trained RN on 8/10/20, will read and sign the JMHS Standards of Behavior, will have a second staff with her when she enters the rooms of R10 and R2, will observe successful approaches other staff utilize and practice using these approaches while another staff is in the room. DON will follow up with NA-C, staff and residents to review progress of performance improvement. Improvement is expected to be in place and successful by 8/19/20. Failure of NA-C to improve performance or a repeat or similar incident will lead to immediate termination. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility LSW and MDS coordinator interviewed all residents on the hall where NA-C works. All residents interviewed denied any	

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F 744	Continued From page 2 negatively towards NA-C, much more frequently than other employees. Expected improvement and time frame identified NA-C would be required to attend the dementia education speaker training on 11/7/19 and submit a summary to the DON. The DON or designee would conduct audit interviews with residents to evaluate care and approach of NA-C. NA-C was to become aware of her approach towards residents and seek assistance from other employees in the event the resident is not responding well. DON and NA-C were to have follow up meetings weekly for 4 weeks. If NA-C's actions did not improve it would lead to a final written warning up to and including termination. Interview on 8/5/20 at 9:00 a.m., with DON identified that on 10/24/20, the date of the written warning, NA-C had submitted her resignation with 11/7/19 as her final working day. Since 11/7/19 was to be her last day of work, she did not attend the required dementia education. During her exit interview with human resources she decided to stay on as a very part time status. The next shift NA-C worked was 12/8/19. NA-C had not completed any dementia training and no audits had been performed. NA-C continued to work with R2. DON confirmed she should have ensured NA-C followed through with the education and auditing. Interview on 8/5/20 at 1:44 p.m., with R2's guardian identified that R2's dementia had progressed and it was now hard to talk with her. The facility had called and notified her of the incident on 10/20/19. She was informed they had addressed it and the NA was no longer providing care to R2. The guardian had no other concerns regarding R2's care.	F 744	concerns with the nursing assistants working with them, all denied feeling afraid of any staff, and all indicated nursing assistants respect their decisions about care. Residents on this hall did not mention NA-C during interviews. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: NA-C attended Dementia Live training program on 8/10/20 prior to the start of her shift. NA-C successfully completed training. All staff will receive the Dementia Live training by 10/31/20. New employees will receive the Dementia Living training within 90 days of employment. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: DON interviewed NA-C, staff working with NA-C and R10 on 8/12/20, 8/17/20, and 8/19/20 to review how approaches were going with residents. NA-C felt the Dementia Live training program was helpful and gave her tools to use when working with Dementia residents. Staff working with NA-C indicated she is using appropriate approaches with R10. DON interviewed R10 who denied being scared of any staff members. DON, or designee, will interview R10 and staff working with NA-C weekly for 4 weeks (weeks of to ensure appropriate approaches continue to be utilized by NA-C. The date that each deficiency will be	

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F 744	Continued From page 3 Interview on 8/5/20 at 2:24 p.m., with NA-C identified R2 would become upset in the afternoons and would yell at her whenever she entered the room. She was unable to care for R2 for awhile as a result. NA-C had been caring for R2 for the last 3 months. She had no additional training after the incident. She was aware of dementia care training at the facility, however had not been to one since the incident. On 8/5/20, SA received a report at 5:29 p.m., SA report identified at 3:10 p.m., R10 reported NA-C was fighting her to get her to change her pants and almost knocked her glasses off and almost pushed her over. NA-C was sent home pending investigation. The 5-day investigation submitted 8/6/20 at 3:44 p.m., identified R10's care plan intervention for Dementia with psychosis includes, calm unhurried approach, leave and come back later, and allow R10 to make decisions about her care. NA-C reported she had been trying to change R10's incontinent product quickly because R10 was fighting and scratching her. NA-C should have tried to allow R10 to make the choice of what type of pad to wear and NA-C could have left and returned later to try again. DON and administrator met with NA-C and she was given a final written warning. NA-C was to participate in and complete the dementia training on 8/10/20. She was to sign the JMHS Standards of Behavior. She was to have a second staff with her when entering R2 and R10's rooms. NA-C was to observe other staff with successful approaches and demonstrate back those approaches. Interview on 8/7/20 at 2:15 p.m., with DON identified NA-C was sent home on 8/5/20 due to	F 744	corrected: 10/31/20	

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F 744	Continued From page 4	F 744		

the incident with R10. The administrator and the DON met with NA-C on 8/6/20. NA-C was to attend dementia training and needed to successfully complete that on 8/10/20 prior to working. If she failed to show up for the training she would not be allowed to work. She would then have to observe other staff with effective communication work with R2 and R10 and then she would have to demonstrate effective communication back. The DON planned to complete audits with residents and staff to assure performance improvement.

Interview on 8/7/20 at 2:50 p.m., R10 identified the staff treat her well.

Interview on 8/10/20 at 12:18 p.m. with NA-C identified R10 had been incontinent and she was attempting to assist her to change as her pants on 8/5/20, R10 did not want to change but her pants were visibly soiled. As she started to perform cares, R10 became upset and started pulling her hair and pulled her glasses off. She should have left but she did not want to leave her without pants on, so she continued to complete the cares. R10 then reported to the abuse to the nurse and she was sent home. NA-C confirmed she was to complete the dementia training later that day and would be observing effective communication and cares and have to demonstrate that back before she would be allowed to work with R2 and R10.

Interview on 8/10/20 at 2:03 p.m., with DON identified her expectation was the care plan would be followed. NA-C could have left R10 safely and re-approached or asked for assistance from another staff.

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F 744	Continued From page 5 Interview on 8/10/20 at 2:25 p.m., with the administrator identified she had now been made aware of the failure to follow through with the performance improvement plan. This should not have been missed and the follow up education and audits should have occurred to prevent reoccurrence. The DON and herself had met with NA-C and there was now a plan in place to assure it would not reoccur. Her expectation was the care plan should have been followed.	F 744		